

Running head: UNCOMPENSATED CARE IN SOUTHWEST TEXAS

UNCOMPENSATED HEALTHCARE WITHIN THE GREATER SAN ANTONIO HOSPITAL
COUNCIL MEMBERSHIP: AN EDUCATIONAL PACKAGE AND CASE STUDY

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The health care organization titles, Savelife Memorial Hospital and Community Hospital, used in this paper are fictitious to preserve the anonymity of the actual organizations. However, the information used is factual and was obtained through interviews and visits to real and functioning facilities. To further protect hospital anonymity, the fictitious names Dent and Sanders were used in the body of the paper and in the reference section.

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Abstract

For the past several years the United States has experienced a robust economy that has created wealth and prosperity for many companies and individuals. However, the health care industry is faced with the growing problem of increased uncompensated care for their services. At the same time there is growing concern over the increase in the uninsured population in the United States. Texas is the nation's leader in uninsured persons with an estimated 24 percent uninsured in 1998. Furthermore, there are an estimated 600,000 Medicaid eligible persons in Texas that are not enrolled in the program.

The Greater San Antonio Hospital Council is a trade organization that has membership in 27 counties in Southwest Texas. As with Texas as a whole, 24 percent of the Hospital Council geographic membership population is uninsured. As a result of the high uninsured population and other less dominant factors, membership experienced over \$503 million in uncompensated care for 1997.

This project focused on two Hospital Council members. One hospital was a rural not-for-profit county hospital and one was an urban not-for-profit county hospital, each with a mission to care for the indigent population in its service area.

Analysis of each facility demonstrated that they are both actively searching for a more efficient manner of caring for the indigent, and that both facilities experienced a positive earnings margin last year. It was discovered that a decrease in emergency room visits, for non-emergent patients, would reduce

the uncompensated care figures enough to build new clinics and staff those clinics.

Political factors are a roadblock for both facilities, with a lack of funding from county government and Medicare reimbursement reductions being the two most impacting. Furthermore, the inability for each facility to accurately identify the undocumented immigrant population has hampered their ability to gain capital through government funding.

The Texas Hospital Association and the State Senate Committee for Border Affairs are presently addressing the areas of uninsured and tracking undocumented immigrants. Controlling these vital concerns will have a direct, positive impact on the amount of uncompensated care reported by Hospital Council Membership.

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UNCOMPENSATED HEALTHCARE WITHIN THE GREATER SAN ANTONIO
HOSPITAL COUNCIL MEMBERSHIP: AN EDUCATIONAL PACKAGE AND CASE
STUDY

INTRODUCTION

For the past several years the United States has enjoyed economic growth that has lowered the unemployment rate and increased consumer confidence, and thus consumer spending. One would think that economic prosperity would equate to a decrease in uncompensated healthcare received at hospitals throughout the country. Unfortunately, this is not the case. In fact, due to the increase in the uninsured population, uncompensated healthcare is on the rise and in rural states like Texas, uncompensated healthcare is a real problem. It is estimated that Texas alone has 3.3 million uninsured adults and 1.3 million uninsured children (Coleman & Lewis, 1998).

The Greater San Antonio Hospital Council is a trade organization with a mission to promote community health that encompasses 27 counties in Southwest Texas. Membership in the Hospital Council consists of 156 members, including 46 hospitals. Many of these hospitals are located in rural areas and have a high medically indigent patient base. Furthermore, urban hospital members are experiencing similar increases in uncompensated healthcare, due to a high indigent population in and around San Antonio.

Texas has developed and implemented many programs to relieve some of the pressure on hospitals and county governments, caused

by treating their indigent population. Medicaid, a federal program administered by the states, is the first level of a three level "safety net" designed to provide health care for many of the uninsured in Texas. Texas ranks third in the nation for total Medicaid spending and is tied with Arizona for first in percentage of uninsured population (Texas Health and Human Services, 1999). Medicaid contracts with medical professionals around the state to provide 2.5 million Texans meeting age and income eligibility criteria established mostly by federal regulations (Coleman & Lewis, 1998).

The second level of the safety net is the hospitals and physicians, which includes Hospital Districts and Public Hospitals.

The third, and bottom layer, of the "safety net" consist of the County Indigent Health Care Programs (CIHCP). This bottom layer is a last resort for those people who do not qualify for treatment in the top two levels. Eligibility for CIHCP is determined by income and resource guidelines, which are tied directly to the guidelines for receiving cash assistance from the federal Temporary Assistance to Needy Families (TANF) program. The current TANF limit for a single adult is \$78 per month, which equates to approximately 11 percent of the 1997 federal poverty level guidelines (Coleman & Lewis, 1998).

The Balanced Budget Act (BBA) of 1997 has negatively impacted the entire healthcare industry. Approximately 70 percent of the Act was funded by cuts in health care spending, mostly Medicare reimbursement, by the government. The impact to

Texas is expected to exceed 5.7 billion in lost revenue through the year 2002. Combine the increase in the uninsured population with Medicare reimbursement cuts and the result is many Texas hospitals operating in a negative margin; which some predict may be as low as 7.8 percent by 2002 (Miller, 1999).

CONDITIONS WHICH PROMPTED THE STUDY

Events, such as the BBA and a continuous rise in the uninsured population, have prompted the Texas Hospital Association to take a closer look at the problem of uncompensated health care and the uninsured and indigent population directly associated with such care. Furthermore, next year is a legislative year in Texas and it is imperative that legislators understand the magnitude of health care delivery for Texas' indigent population, as well as the various components of the many programs designed to care for the indigent and uninsured in Texas.

Because of the many counties served by the Greater San Antonio Hospital Council (GSAHC), the Texas Hospital Association requested that GSAHC develop an educational tool for the many legislators within GSAHC's region. Additionally, GSAHC's membership is interested in an analysis of the financial impact that uncompensated care, particularly care of the indigent, has had on its hospitals.

Texas legislature has developed a blue ribbon task force to investigate the sudden rise in uninsured Texans. The task force is soliciting case studies to use in their final report.

Texas House Bill 1398, Indigent Health Care, is a positive approach to health care delivery for the state's indigent population; however, there is still fine tuning necessary and new information is needed to promote further changes concerning indigent health care. With the 77th Texas legislature meeting next year, information gathered by the development of an educational tool and a case study of the financial impact to its hospitals, GSAHC has an opportunity to benefit membership. By demonstrating the magnitude of uncompensated health care in Southwest Texas, GSAHC can influence changes that may improve the present indigent health care program.

STATEMENT OF THE PROBLEM OR QUESTION

What is the financial impact of uncompensated care at hospitals within the GSAHC membership? Is there a relationship between the rise in the uninsured population, number of emergency visits and uncompensated care at these hospitals?

There is an "alphabet soup" of information on the many different programs for treating the Texas indigent population. However, there is no comprehensive summary document that legislators can use to understand the complexity of the indigent health care program.

LITERATURE REVIEW

Uncompensated health care is certainly a major concern within the health care industry today. Hospitals spend billions of dollars each year treating patients that they never gain revenue from (Archer & Townsend, 2000). Texas is affected more than most states because of its large uninsured population (Texas Health and Human Services, 1999).

For reporting and statistical purposes, uncompensated care is the amount of bad debt and charity care measured in actual expenses incurred by a hospital when providing medical care to individuals who cannot pay or do not pay all or some of the cost of services provided to them. Bad debt is reported for patients who have insurance, or the ability to pay, and don't. Charity care is reported after treating patients who do not have the means to pay for their health care (McCue, Millikan, Zelman, 1998).

Texas has developed a three level "safety net" for providing health care to its indigent population. The top level is Medicaid. When Medicaid does not cover a person, they then fall into the second level, which are hospitals and physicians. Hospitals and local physicians will often treat the indigent free of charge and record it as charity care. If they are not treated at the second level, then persons without insurance fall into the last level for health care. The bottom level of the "safety net," the County Indigent Healthcare Program, is for those indigent persons who fail to qualify for the top two level and meet minimum requirements.

In order to understand the problem of uncompensated care, it is important to know the different federal and state programs designed to provide for those most responsible for such care—the indigent population.

MEDICAID

The top level of Texas' "safety net" for treating indigent persons is Medicaid. Medicaid, Title XIX of the Social Security Act, is a Federal-State matching entitlement program that pays for medical assistance for certain vulnerable and needy individuals and families with low incomes and resources. Medicaid became law in 1965 as a jointly funded cooperative venture between the Federal and State governments to assist States furnishing medical assistance to eligible needy persons (Sultz & Young, 1997).

Medicaid is the largest source of funding for medical and health-related services for America's poorest people. In 1996, it provided health care assistance to more than 36 million persons, at a cost of \$160 billion dollars (Health Care Finance Administration, 1999).

Within broad national guidelines established by Federal statutes, regulations and policies, each State: (1) establishes its own eligibility standards; (2) determines the type, amount, duration, and scope of services; (3) sets the rate of payment for services; and (4) administers its own program. Medicaid policies for eligibility, services, and payment are complex, and vary considerably even among similar-sized and/or adjacent States. Thus, a person who is eligible for Medicaid in one

State might not be eligible in another State; and the services provided by one State may differ considerably in amount, duration, or scope from services provided in a similar or neighboring State. In addition, Medicaid eligibility and services within a State can change during the year (Health Care Finance Administration, 1999).

States have some discretion in determining which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. To be eligible for Federal funds, States are required to provide Medicaid coverage for most individuals who receive Federally assisted income maintenance payments, as well as for related groups not receiving cash payments.

Mandatory Medicaid eligibility groups are: low income families with children who meet certain eligibility requirements; Supplemental Security Income (SSI) recipients; and infants born to Medicaid-eligible pregnant women. Medicaid eligibility must continue throughout the first year of life so long as the infant remains in the mother's household and she remains eligible, or would be eligible if she were still pregnant. Furthermore, children under age 6 and pregnant women whose family income is at, or below, 133 percent of the federal poverty level are also eligible. States are required to extend Medicaid eligibility until age 19 to all children born after September 30, 1983 in families with incomes at or below the Federal poverty level. This coverage is phased, so that by the year 2002, all poor children under age 19 will be covered. Once

eligibility is established, pregnant women remain eligible for Medicaid through the end of the calendar month in which the 60th day after the end of the pregnancy falls, regardless of any change in family income. States are not required to have a resource test for these poverty level related groups (Health Care Finance Administration, 1999).

Medicaid coverage in Texas is extensive with over 2.5 million persons enrolled in 1997. Medicaid expenditures, in Texas, exceeded \$7 billion dollars in 1997 (Texas Health and Human Services, 1999). Even with this large number of covered lives, the Texas Health and Human Services is concerned that not all Texans that are eligible are enrolled. Therefore, Texas has initiated outreach programs to reach eligible persons.

Children's Health Insurance Program

The Children's Health Insurance Program (CHIP) was established by the Balanced Budget Act of 1997. On May 28, 1999, Texas Governor George W. Bush signed a new law-enacting CHIP in Texas. CHIP is available to uninsured children from families whose income is up to twice the federal poverty level, if they are not already eligible for Medicaid. Texas' program will also be available to all children of legal immigrants in the CHIP income group who meet CHIP eligibility criteria.

Eligibility for CHIP in Texas is available to uninsured children from families with net incomes at or below 200 percent of the federal poverty (Appendix A). CHIP is designed to target a large portion of Texas' uninsured children. Official state estimates put this population in 2001 at roughly 471,000 out of

a projected 1.4 million uninsured Texas children (Appendix B). Unfortunately, the state projects that no more than 67 percent of eligible children will enroll in the CHIP program. The state projects a maximum enrollment of about 281,000 in 2001, growing to 448,000 by 2004. As of May 1999, Texas had enrolled over 107,000 children into CHIP (Center for Public Policy Priorities, 1999).

A majority of the uninsured children in Texas are at or below the poverty line, thus qualifying them for Medicaid, thus making them ineligible for CHIP enrollment. This has created a decreased enrollment in CHIP and caused many of these children to go without health care coverage because they are not enrolled in Medicaid.

Federal Law requires that CHIP coverage be available to legal immigrant children who arrived in the U.S. prior to August 22, 1996 on the same terms as citizen children. Children who arrived after that date are subject to a five-year exclusion from CHIP, after which time federal law requires states to include them. Texas has allowed for immigrant children subjected to the federal five-year bar to immediately qualify for CHIP. Texas will use tobacco settlement dollars to fund this added benefit to their CHIP (Center for Public Policy Priorities, 1999).

Like Medicaid outreach, CHIP outreach programs in Texas are a double-edged sword. Legislators understand that there is a great need to reach out to the uninsured children in Texas; however, because most of the uninsured children are Medicaid

eligible, outreach will facilitate the growth of Medicaid enrollees and thus an increase in Medicaid spending for Texas.

Hospitals and Physicians

The second, or middle level, of the "Safety Net" for indigent health care is the hospitals and physicians. Hospital districts, public hospitals, private non-profit hospitals, private for-profit hospitals and state-run facilities provided an estimated 4.4 billion dollars in uncompensated care to Texans in 1997 (Archer & Townsend, 2000).

Hospital districts are located in 109 of Texas' 254 counties and have a mandate to provide health care for their indigent population. Required services of hospital districts are limited to those defined by the Texas Constitution and the statute creating the hospital district. Eligibility standards for hospital districts vary throughout the state and can be as low as 11 percent, or as high as 200 percent of the federal poverty level (Coleman & Lewis, 1998).

There are currently 24 public hospitals operating in Texas. These are hospitals owned, operated or leased by a county, city, town or other political subdivision of the state. Public hospitals and hospital districts are legally liable for serving residents in their service areas that may include all or a portion of a county.

In addition to hospital districts and public hospitals, there are approximately 350 private non-profit and for-profit hospitals operating in Texas. Non-profit hospitals, which receive certain tax exemptions from ad valorem, franchise and

sales taxes, have a statutory obligation to provide charity care and provided just under one-third of the \$4.4 billion in uncompensated care provided by Texas acute care hospitals in 1997. In 1996, 49 percent of the uncompensated care was provided by public hospitals, 34 percent was provided by non-profit hospitals, and 17 percent was provided by for-profit hospitals. Charity care accounted for 53 percent of total uncompensated care in that same year (Archer & Townsend, 2000).

Along with hospitals, private physicians often provide health care services free of charge to those who cannot afford to pay. The extent of uncompensated care is difficult to monitor in private physician's offices because they are not required to submit reports to the state.

County Indigent Health Care Programs

The bottom level of the "safety net" is the County Indigent Health Care Program (CIHCP). There are 136 counties in Texas that administers a CIHCP. By law, CIHCPs are the payers of last resort and are charged with providing financial assistance only if other sources of payment are not available. Counties operating CIHCPs provided health care services to approximately 17,000 Texans in fiscal year 1997 (Coleman & Lewis, 1998).

The Texas Indigent Health Care and Treatment Act of 1985 establishes basic standards of eligibility, services and payment for all counties operating a CIHCP. Eligibility is determined by income and resource guidelines, which are tied directly to the guidelines for receiving cash assistance from the federal

Temporary Assistance to Needy Families (TANF) program.

Persons who do not qualify for Medicaid, but otherwise meet TANF eligibility guidelines, may receive health care benefits under the Act. Counties may adopt more generous standards, but at a minimum must abide by the state requirements (Coleman & Lewis, 1998).

Mandatory services under CIHCP are based on the list of mandatory services that were required under Medicaid in 1985. These services include medically necessary inpatient and outpatient hospital care, physician services, skilled nursing facility care and three prescription drugs per month.

A county operating a CIHCP qualifies to receive state assistance funds once it has spent eight percent of its general revenue tax levy on mandatory care for eligible individuals. This was lowered from the act's original 10 percent threshold, because of the inability of many rural counties to meet the percent requirement. There is also underlying concern that some counties are not using appropriated funds to treat their indigent population due to the urgent demands for county infrastructure, roads, and police and fire services (Jones, 1999).

Temporary Assistance for Needy (TANF)

Formerly: Aid to Families with Dependent Children, TANF originated in the 1935 Social Security Act, which provided federal funds under Title IV of the Act to match state funds. The purpose of the program is to provide financial and medical assistance to needy dependent children and the parents or

relatives with whom they are living. Eligible TANF households receive monthly cash and Medicaid benefits. The federal portion of program funds were provided via a block grant to states as a result of federal welfare reform signed into law on August 22, 1996. The Texas Legislature determines the amount of state money appropriated to the TANF Program. The Texas Department of Human Services (TDHS) then determines the maximum grant amount for each household size. In December 1996, there were 618,431 TANF recipients in Texas. Eligible families cannot have more than \$2,000 in resources or \$3,000 if the household includes a relative who is at least age 60 or who is disabled.

TDHS determines a household's financial eligibility based on an amount, which represents 100 percent of the estimated cost necessary to meet basic needs for one month according to household size. TDHS determines benefits based on an amount that equals 25 percent of the budgetary needs amount and pays a maximum TANF Grant, which is approximately 17 percent of the federal poverty level (Texas Health and Human Services, 1999).

UNINSURED

Uncompensated care is directly related to uninsured patients receiving care in a health treatment facility. One contributing variable responsible for the increased uncompensated care experienced throughout the GSAHC membership is the growing uninsured population within the region. Whether the patient is poor, unemployed, or above the federal poverty level and working, the results are the same if they are uninsured. Patients without insurance are less likely to pay for their care

and are more likely to wait until they are in desperate need of treatment before they present to a health care facility, thus resulting in uncompensated care at the highest cost.

In the past hospitals would cost-shift to avoid significant loss due to uncompensated care. However, in today's managed care environment, cost shifting is usually not an option because of the decreasing number of patients covered by traditional indemnity insurance and because of decreasing reimbursement rates.

Many experts attribute the rise in the uninsured population to the welfare reform law passed in 1996. A study published by Urban Institute researchers reveals that in 1997, one year after leaving welfare, 49 percent of women and 30 percent of children were uninsured. The complexity of Medicaid eligibility laws, as well as, the stigma of being associated with welfare may account for the fact that many ex-welfare recipients do not obtain Medicaid coverage. Furthermore, former welfare recipients often are employed in jobs that do not offer health insurance (AHA News Now, 2000).

This lack of coverage comes at a time when employer-based health insurance covers more than 152 million American workers and their dependents, in addition to an estimated 17 million retirees and family members. However, there has been a dramatic shift from conventional employer-based (also known as indemnity or fee-for-service) insurance plans to managed care plans. Since 1988, conventional insurance plans have declined from 73 percent to only nine percent (Levitt et al., 1999).

This alarming trend suggests that employers are more worried about costs than quality. In a survey performed by The Kaiser Family Foundation and Health Research and Educational Trust, it was stated that 72 percent of all firms say they are worried that health care costs will increase faster than they can afford. Furthermore, 70 percent say they are worried they will have to cut back the scope of benefits they offer or the amount they contribute towards health insurance for their workers, and 65 percent say they are worried they will have to switch health plans because of costs. Only 26 percent of firms say they are worried they will have to switch health plans because of concerns for quality. Larger firms are more likely to express concern about quality than smaller firms (Levitt et al., 1999).

Economic Impact

The economic impact of a hospital on its community is often over-looked by public officials. There are many variables that must be considered when analyzing economic impact on a community. According to the Goodman Group, Inc., type of employment, wages and salary, purchases from vendors, benefits paid by the hospital, retail sales as a result of staff spending, and purchases by hospitals are all factors that contribute to the overall economic impact (The Goodman Group, 1999). That being said, uncompensated care's impact on hospitals could directly affect communities if the affected hospitals should cease operations. There is concern that rural hospitals in Texas may be forced to close, because they have few

financial reserves, and are often posting a negative margin at the end of the reporting period.

PURPOSE STATEMENT

The purpose of this graduate management project is to develop an educational tool that explains uncompensated health care and indigent health care assistance programs, which can be used by Texas Senators and Representatives during the 77th Legislative session 2000 and the Texas Senate Committee on Border Affairs. This project will also demonstrate the increase in uncompensated health care and the increase in the uninsured by each county within the GSAHC membership. Specific demographics, such as age and income level will assist the GSAHC as they formulate their strategic plan for the next year. The project will attempt to illustrate, at the macro level, the possible financial impact that uncompensated health care may have on rural and urban hospitals within the GSAHA health district. It is hoped that in providing such a tool, GSAHC members and legislators will see the value of enrolling the indigent population in one of the many programs designed to assist indigent persons with medical treatment. The main purpose of this study is to illustrate a need for further detailed research in the areas of uncompensated health care and the rising uninsured population.

METHODS AND PROCEDURES

The methods and procedures are broken into two sections. First, the method and procedure used to develop an educational tool on uncompensated health care, and second, the method and procedure used to evaluate the economic impact of treating patients without compensation.

EDUCATIONAL TOOL

Step 1: Mode of health care delivery by county

The first step is to identify all the counties within the GSAHC membership and list, in a matrix, what type of health treatment system they use to treat their indigent population (Appendix C), as well as, which state legislator represents each particular county (Appendix D).

Step 2: Identify indigent population numbers

The second step is to identify the size of the indigent population within each county (Appendix E) and then to identify the total expenditures for uncompensated care in each county (Appendix F), including the uninsured population (Appendix E). This information will help identify those counties that have a greater problem with caring for their indigents. Furthermore, by having uninsured and uncompensated care numbers, legislators can visualize the magnitude of non-reimbursed health care problem.

Step 3: Develop Glossary

The third step is to develop a detailed glossary of terms (Appendix G), along with a descriptive explanation of each type of indigent health care treatment program, such as TANF, CHIP, CIHCP, Hospital Districts and Medicaid. This will allow interested parties to quickly identify the differences between the programs.

FINANCIAL IMPACT

The financial impact of uncompensated care will be assessed and presented using a case study format. A sample of two hospitals will be assessed. The hospitals were selected to represent a rural, not-for-profit public hospital, and an urban, not-for-profit public hospital. A Hospital Authority located in a South Texas county and a Hospital District located in a major city in South Texas were chosen as the rural and urban facilities, respectively, for this study. Although different in size (51 beds vs. 547 beds), both hospitals have a similar mission with regard to providing care for the indigent populations of their respective counties.

Step 1 Analysis of the Population

The first step was to gather population statistics on the indigent population within the studied counties. Indigent

populations were defined as those people within their respective county, which have incomes equal to or lower than 100 percent of the Federal Poverty Level (FPL). A percentage of indigent population to total population was calculated for each county. The uninsured population within each county was also reported to illustrate the growing concern of uninsured health care consumers.

Of great interest to each hospital, and their respective counties, was the number of uninsured children. Children under the age of 18 and who were below the federal poverty level were identified for each county.

Step 2 Analysis of the Hospital

The second step was to move into the hospital and analyze the financial and possible resulting quality impact that uncompensated health care had on each institution.

This approach was used to: identify the amount of uncompensated care reported within each institution, identify the services that were most often unreimbursed, identify possible trends in usage.

The final step was to identify how a patient was classified, i.e., either as bad debt or charity care, and how a patient was classified as medically indigent. There was an attempt to identify possible delinquent billing and other inadequacies by the reimbursement departments. Interview and personal observation was the method of obtaining such information.

FINDINGS AND RESULTS***Case I Rural Hospital***

The rural hospital used in the case study is real. The numbers were obtained from data received from both the hospital and the Texas Hospital Association. However, for purposes of maintaining anonymity, the rural hospital was given the fictitious name "Savelife" Memorial Hospital.

BACKGROUND

Savelife Memorial Hospital is a 51-bed sole community provider and the center for medical services for its county and four surrounding counties. Savelife is the County Hospital Authority created by the Commissioner's Court of the county on January 26, 1968 (Moody & Fikes, 1998).

Savelife Hospital is under the control and management of a seven-member Board of Directors. The Commissioner's Court appoints three of the Directors, and the existing Board appoints the successors for the remaining four positions.

Savelife Hospital possesses a unique patient service area considering that the surrounding four counties do not contain acute care facilities. It is important to note that, in aggregate, these counties are larger than this country's smallest states.

Savelife Memorial's five-county-service-area is home to over 45,000 citizens (Texas Department of Health, 1999). This number does not include migrant workers in the summer or visitors from the North ("snowbirds") in the winter months.

Savelife Memorial Hospital is the only facility in the five-county region that offers comprehensive medical care with emergency physicians on a 24-hours per day basis. This presents a problem for Savelife Hospital when other outlying clinics close by creating an influx of non-emergent cases presenting to the emergency room after hours. Furthermore, over-crowded emergency rooms present a quality of care issue for Savelife Memorial Hospital.

HEALTH CLINICS

In 1992, Savelife Memorial Hospital received a Rural Health Transitional Grant, which enabled the Hospital to develop a sub-specialty clinic for the citizens of the town and surrounding area. This clinic houses over twenty specialty physicians who travel to Savelife Memorial and see patients in an outpatient clinic setting. These sub-specialties include neurosurgery, podiatry, ophthalmology, mental health services, urology oral surgery, dermatology, cardiology, rheumatology, neurologist, epilepsy, etc. This particular clinic had an average of 750 visits per month and over the last year in excess of 7,000 people received care in Savelife Hospital and did not have to travel outside of the service region to see a specialist (Dent, 1999).

In addition to the sub-specialty clinic, Savelife also runs the Savelife Memorial Hospital County Health Clinic. This federally qualified health clinic is funded by federal and state grant funds. The clinic treats indigent patients until the

clinic's resources have been depleted.

To help offset the deluge of expensive emergency room visits, Savelife Hospital opened a Hospital-based Rural Health Clinic in October 1995 as a means of developing non-emergent care for patients presenting themselves as clinical cases in the hospital's emergency room. In 1996, Savelife Memorial Hospital opened a satellite rural Health Clinic in a small town 22 miles from Savelife's location. This clinic is the only locally assessable health care clinic for that area. The addition of the Rural Health Clinics is intended to decrease the amount of non-emergent cases presenting in the emergency room (Dent, 1999).

UNCOMPENSATED CARE

Uncompensated care is defined as health care services for which the patient and/or the payer either was not billed or failed to pay. Uncompensated care includes both charity care (services provided to patients at no charge) and bad debt (anticipated payment for services a provider did not receive). The value of uncompensated care includes the estimated costs of providing care associated with both charity and bad debt. Uncompensated care does not include the difference between costs and charges for cost-based payers and losses arising from negotiated discounts. Because of this, Savelife Memorial Hospital is reporting to the American Hospital Association uncompensated care numbers that are actually far less than the total uncompensated care provided at their facility.

Savelife Hospital currently pays for the provision of uncompensated care in two ways. First, through subsidies from state and local governments to cover the cost of charity care. Second, shifting uncompensated care costs to other payers. The problem for Savelife Hospital is that about 75 percent of its reimbursement comes from Medicare and Medicaid, thus leaving the remaining 25 percent of payers to absorb the cost of uncompensated care in the form of bad debt.

Savelife reported \$3,668,727 in uncompensated care (bad debt and charity care) in 1999. If contractual discounts and adjustments to Medicare and Medicaid payments are added, the uncompensated care number swells to \$16,319,946. For the \$12,651,219 loss in Medicare and Medicaid contractual adjustments, Savelife Hospital received \$1,155,662 in disproportionate share compensation from the State of Texas (Moody & Fikes, 1999). Disproportionate share is designed to help offset those hospitals that see a disproportionate share of Medicaid and Medicare patients. It is clear that the disproportionate share dollars received by Savelife Hospital in 1999 fell far short of the costs associated with treating Medicaid and Medicare patients. In fact, from 1997 through 1999 Savelife Hospital averaged over \$13.9 million in uncompensated care when contractual discounts and adjustments are included in the computation (Moody & Fikes, 1999).

Along with disproportionate share dollars, Savelife is supposed to receive 10 percent of the counties levied taxes to care for indigent persons (those persons at or below 100 percent

of the FPL) under the State's County Indigent Health Care Program. Texas provides matching funds for indigent health care, 90 cents on the dollar, after a county has expended eight percent of its total operating expenditures on indigent health care. Savelife Memorial Hospital's representing county expended less than 1 percent (.86) for indigent health care, far below the required eight percent for State fund matching (Texas Department of Health, 1999). Unlike Hospital districts, hospital authorities, such as Savelife Hospital, are not granted taxing authority and thus rely heavily on dollars received through the County Indigent Health Care Program. However, Savelife does receive a one-half cent sales tax to care for the indigent population.

DEMOGRAPHICS

Of the 45,000 plus citizens served by Savelife Hospital, over 35 percent were estimated to be in poverty in 1995, or below 100 percent of the federal poverty limit. Furthermore, it is estimated that over 26 percent were uninsured in 1998, a large portion of which were under the age of 18 years. In comparison, Texas as a whole estimates that 24.5 percent of its population is uninsured with the United States number coming in at 16.3 percent (Texas Hospital Association, 2000).

OBSERVATIONS

I visited Savelife Hospital to identify problem areas in respect to the rise in uncompensated care and its affect on

health care delivery. The Hospital staff was very receptive and interested in assisting me as I studied their hospital.

I identified four key areas of concern that seem to have a direct impact on the amount of uncompensated care at Savelife Hospital. They are: (1) The ability for staff to classify patients as charity care, (2) the ability to enroll Medicaid eligible patients, (3) political agendas, and (4) the rising uninsured population in and around the geographic region.

CLASSIFICATION AS CHARITY

In order for Savelife to receive financial assistance from the state for charity care, the hospital must first be able to justify its numbers to the state. In order for individuals to be labeled as charity care, they must meet the requirements of that particular hospital. Savelife has a charity care policy that allows those individuals whose incomes are less than 200 percent of the federal poverty level and are not eligible for other assistance, such as Medicaid or the County Indigent Health Care Program, to be classified as charity and reported as such.

Savelife is having a problem identifying qualified individuals. The charity care policy is in place, but there is not enough staff to spend the extra time needed to identify qualified patients. Therefore, Savelife documents these patients under bad debt and loses the opportunity to receive state assistance for them.

It is recommended that all staff be educated on the

importance of classifying qualified patients as outlined in Savelife Hospital's Charity Care Policy Statement.

Furthermore, a cost benefit analysis should be conducted to determine if an FTE hire would improve the success of their Charity Care program.

MEDICAID ENROLLMENT

Savelife Hospital has a social program office that employs one full-time social worker to enroll patients into Medicaid. Because of the strict requirements to become eligible for Medicaid, along with the difficult application process, patients who might otherwise be eligible for Medicaid are overlooked and often fall into the bad debt category. After interviewing the social worker responsible for enrollment, it was clear that there is a stigma attached to the Medicaid label that most patients don't want to be associated with. The social worker noted that the community Savelife Hospital is located in is a favorite for illegal drug activity, due to its close proximity to the Mexican boarder. Unfortunately, many of the patients that present for care are involved in the drug trade or are undocumented aliens. Consequently, they are afraid they will be discovered if they allow for asset testing, which is required by the state to qualify for Medicaid. The end result is often a visit to the emergency room, no medical follow-up, no preventive health care, and a consequent increase in uncompensated health care.

POLITICAL FACTORS

The most glaring political factor to me was the lack of indigent health care spending by the county. When asked to produce information concerning indigent health care spending, the county declined. It was in the best interest of Savelife Hospital that this issue was not pursued. The Administrator at Savelife confided that he has yet to receive complete funding for the treatment of indigent persons. As previously noted, the county reported that they only expensed .86 percent of their budget for indigent health care, much less than the required eight percent for State matching funds. Because of the political backlash of "pushing the issue," the Administrator feels that it would not be beneficial to his Hospital if he were to demand the money.

The County Judge is responsible for allocating indigent health care funds to the hospital. At the same time, there is pressure from the voters to improve roads, schools, and fire and police protection, without raising taxes. According to the Administrator, most voting residents see health care as a low priority, until they need it. The County Judge has the difficult task to decide how taxes and appropriated State funds are spent. Because the County Judge is an elected official, I suggest that he or she feels the need to appease the voters, which sometimes leads to fund allocation based on special interest group wants and not on county needs. It is common knowledge in Texas that many of the counties that have received money from the tobacco lawsuit settlement have not allocated

that money to health care. However, it should be noted that counties are not required by law to spend tobacco money on health care. Further research should be done to see if uncompensated care would go down in county Hospital Authorities and Hospital Districts if tobacco settlement dollars were spent on health care.

UNINSURED

In 1998 the uninsured population in Texas reached a staggering 24 percent and is expected to rise. The United States as a whole is 16 percent and is also on the rise. The uninsured rate in Savelife Hospital's service area is about 26 percent with about one-third of that being under the age of 18 years (Texas Hospital Association, 2000). There are approximately 600,000 people in Texas who are not enrolled in Medicaid and yet they are eligible (Texas Health and Human Services, 1999). There is presently a taskforce addressing this issue in Texas. It is important that researchers study the uninsured population across economic boundaries. For example, not all uninsured persons are poor and unemployed, as is often perceived by the general public. But if county residents are working, then why are they not covered for health care? I believe the answer is within the demographics of the service population. There is a large unskilled and uneducated labor force within Savelife Hospital's service area. People in the area are employed in minimum wage jobs that often forego health coverage for their employees. Furthermore, families in this

working poor wage bracket will decline health coverage if given the choice between higher pay and health coverage. I understand that my assumptions should be supported by statistical data; therefore, I recommend further study in the area of who is uninsured and why.

Treatment of the indigent population is only part of uncompensated care at Savelife Hospital. Initially, I was researching indigent health care treatment and its relationship to uncompensated care. I found that the uninsured as a whole, poor classification of patients, and political pressures, along with the indigent population, are key contributors to Savelife Hospital's growing amount of uncompensated care.

FINANCIAL IMPACT

In 1999, Savelife Memorial had 13,696 emergency room visits (the highest uncompensated service in the hospital) at an average cost of \$233 a visit. The same visit at a primary care clinic would cost Savelife an average of \$35 a visit. Also of note is the \$590,392 that Savelife documented as uncompensated care for non-trauma care in the emergency room for 1999 (V. Lopez, personal communication, December 15, 1999).

The impact of the uncompensated care in the emergency room, not to mention the entire hospital, is significant. For example, if half of the emergency room patients that were treated in 1999 were treated in a primary care clinic, Savelife Memorial would have saved approximately \$922,021 (Appendix H). This amount would be enough money to add 14.5 physician's

assistants to the staff of the primary care clinics, thus increasing access to care for the county residents. Furthermore, the money could help fund a new 30,000 square foot clinic that would cost approximately three million dollars (V. Lopez, personal communication, December 15, 1999). The savings are estimated from the dramatic decrease in treatment cost for an emergency room visit (\$233 per visit average) to the treatment cost for a primary care clinic visit (\$35 per visit average)(V. Lopez, personal communication, December 15, 1999).

CASE II URBAN HOSPITAL

The urban hospital used in this case study is real. The numbers are obtained from data received from both the hospital and the Texas Hospital Association. However, for purposes of anonymity the urban hospital is given the fictitious name "Community" hospital.

BACKGROUND

Established in 1955 as the County Hospital District, the Community Health System facilities include Community Hospital (the focus of this case study); Community Health Center-Downtown; Community Center for Community Health; Community Family Health Center-Southwest; Community Family Health Center-Southeast; Community Family Health Center-Basse; and El Carlos Clinic.

The Community Health System currently has 4,000 employees with an operating budget of \$360.8 million for 1999 (M. Cotton,

personal communication, March 13, 2000).

Community Hospital is a 552-bed acute care hospital serving as the primary teaching facility for the local Medical University. The hospital opened in 1968 and boasts the first heart, hear-lung and lung transplants and first newborn heart transplant.

Community Hospital is one of three trauma centers in the city, with physicians representing every medical specialty and is staffed around the clock, providing emergency care for over 90,000 patients annually (Potts, 1999). Community offers many services, but considers trauma care, neonatology, pediatric cardiac surgery, fetal diagnostic services and organ and bone marrow transplantation as their champions of excellence.

As the largest facility within a multiple facility hospital system, Community Hospital has absorbed the brunt of the responsibility for caring for the county population that is unable to afford health care and/or doesn't have health insurance. Because of this responsibility, Community Hospital has continued to expand its infrastructure throughout its existence to keep pace with the growing poverty and uninsured population in the county.

HEALTH CLINICS

Community Health Center-Downtown

The Community Health Center-Downtown is the Health System's major outpatient healthcare center where patients receive both primary and specialty care as outpatients. Services offered at

the Community Health Center-Downtown include cardiology, pediatrics, family medicine, orthopedics, ophthalmology, diabetes intervention and clinical research. The center also provides full-scale prenatal services for normal and complicated pregnancies.

With more than 300,000 outpatient visits each year, the Community Health Center-Downtown is among the busiest facilities of its kind (Media Relations, 1999)

Community Center for Community Health

Community Center for Community Health is the ambulatory care center for the city's West Side. Created with the assistance of a major grant from the Texas Diabetes Council, Texas Diabetes Institute is the key program of the Community Center. The Center also includes hyperbaric wound care and renal dialysis. Among the additional programs on site is the Village of Hope, a center for children with developmental disabilities, which is housed in several renovated cottages located on 10-acres of land.

Community Family Health Centers

There are four Family Health Centers geographically dispersed throughout the city that are designed as neighborhood-based health centers which focus on preventive health care for the entire family.

UNCOMPENSATED CARE

As stated previously in the Rural Hospital Case Study uncompensated care is defined as health care services for which the patient and/or the payer either was not billed or failed to pay. Uncompensated care includes both charity care (services provided to patients at no charge) and bad debt (payment for services a provider anticipated, but did not receive). The value of uncompensated care includes the estimated costs of providing care associated with both charity and bad debt. Uncompensated care does not include the difference between costs and charges for cost-based payers and losses arising from negotiated discounts. Community Health Systems reported an average of over \$155 million per year for the past five years to the American Hospital Association, escalating to over \$173 million in 1999 (M. Cotton, personal communication, March 13, 2000).

In 1997, in an effort to reduce the rising cost of uncompensated care at their facility, Community Health System spearheaded a program called CarePlus. According to CarePlus's Vice President/Executive Juanita Sanders, in just one year of administering CarePlus, Community Hospital noticed a decrease in emergency room visits, which corresponded with a decrease in uncompensated care. The emergency room is Community Hospital's most uncompensated service.

Mrs. Sanders went on to say that CarePlus replaced Community Health System's CostShare program for indigent and needy county residents in April 1997. She stated that CarePlus is more

efficient than CostShare at verifying county residency and managing patient access to services.

CarePlus services are managed or arranged by the County Hospital District Tax Division, which contains the Member Services and Education Department that runs CarePlus. CarePlus obtains most of its medical services "in-house" through the Community Health System's division of Clinical Expertise, which runs Community Health System's hospital and clinics. Clinical Enterprises contracts for services on behalf of CarePlus when they are not available in-house. The Clinical Enterprises Division has a close working relationship with The University of Texas Health Science Center at San Antonio for physician services.

As an exception to CarePlus's use of Clinical Enterprises as its agent for services, CarePlus has arranged contracts with two Federally Qualified Health Centers (FQHCs) to expand primary care services.

CarePlus members are assigned a "medical home" at CarePlus clinics. When sufficient physicians are available, CarePlus matches a member to a specific primary care physician for management of medical services. Members receive primary care services at the Community Health System clinics and the FQHCs, and hospital inpatient and outpatient services at Community Hospital. Members must use network facilities and services to receive financial assistance. Mrs. Sanders explained that special situations for out-of-network care are considered on a case-by-case basis.

To be eligible for CarePlus, a program member must be a resident of the County. There is no income limit. However, financial assistance rules make it comparatively expensive for anyone other than the needy or indigent to participate. Mrs. Sanders stated that in most cases, members, whose income is above approximately 200 percent of the Federal Poverty Level, pay the total amount for all services received.

CarePlus is generally the payer of last resort. However, the County residents who have other health care coverage may be eligible for CarePlus membership to receive those services not covered under their other benefit plans. Sanders added that members are evaluated for continuing eligibility at least once annually.

In an effort to make each CarePlus member contribute to the cost of his or her health care treatment, CarePlus has established a unique policy for member liability. CarePlus calculates a maximum family liability based on a family's Federal Poverty Level, gross family income, and family size. The formula is (annual income) X (percent of poverty) X (11 percent) (J. Sanders, personal communication, February 18, 2000). When a member is enrolled in the program, CarePlus sets up an account that cannot exceed the maximum family liability. CarePlus enters into the account the charges for services received by the member, up to the liability limit. A member has 48 months from the date of the most recent service to pay off the total account balance. Sanders stated that it is not uncommon to have CarePlus members make 25-cent payments.

Mrs. Sanders stated that there has not been a cost-benefit analysis performed on the CarePlus program; however, she stated that collections resulting from CarePlus have increased 300 percent since its inception in 1997.

DEMOGRAPHICS

Of the 1.3 million plus citizens served by Community Health System, over 19 percent were estimated to be in poverty in 1995, or below 100 percent of the federal poverty level. Furthermore, it is estimated that over 24 percent were uninsured in 1998, with just fewer than 30 percent of the uninsured under the age of 18 years. In comparison, Texas as a whole estimates that 24.5 percent of its population is uninsured with the United States number coming in at 16.3 percent (Texas Hospital Association, 2000).

OBSERVATIONS

In order to maintain a parallel comparison of two facilities with similar missions, I evaluated the same four areas for both Savelife Memorial Hospital (Case I, Rural Hospital) and Community Health System (Case II, Urban Hospital). As with Savelife, I examined Community's ability to classify patients as charity care, ability to enroll Medicaid eligible patients, political agendas and roadblocks, and the rising uninsured population in and around the geographic region.

Although the scope of responsibility for Savelife and Community is vastly different, their mission to treat the indigent populations for their respective counties suggests that

both entities experience similar problems with increasing levels of uncompensated health care.

CLASSIFICATION AS CHARITY

Community Health System has been a pioneer in charity classification through their CarePlus Program. CarePlus is equivalent to other public and county hospital's charity care policies, which are required by Texas law. As stated earlier, Community Health System has benefited from this program through patient satisfaction and increased reimbursements. CarePlus is unique in that it allows every patient, regardless of poverty level, to take an active role in paying for his or her health treatment. Using an asset-based scale (Appendix I) has allowed Community to develop individual payment plans that have, in a sense, restored pride into many of the patients who in the past have been unable to pay for their treatments.

One of the drawbacks of the CarePlus Program is that it does not have access to managed care software that integrates data on enrollment, claims, benefits, and services to patients. Because CarePlus is modeled after the managed care model, such software should be procured to enhance the efficiency of Community's charity care operation. They presently continue to monitor the said areas through systems that do not cross-reference each other. In fact, Community does not maintain their claims data electronically. However, according to Juanita Sanders, Community Health System has made procurement of a managed care system a strategic objective and hopes to have a system up and

running this year.

Community Health System fully supports the CarePlus program, and has demonstrated such support by increasing the FTEs for running the program from 42 to 74 (J. Sanders, personal communication, February 18, 2000). Furthermore, the rapid growth of the CarePlus program has enticed many physician groups to offer their services to Community Health System and their CarePlus Program, thus expanding access to a very needy population.

MEDICAID ENROLLMENT

As with many of the health systems in Texas and throughout the nation, Medicaid enrollment has continued to be a major concern for Community Health System. Community has used their CarePlus program to help capture Medicaid eligible persons. To do this, CarePlus acts as the overall umbrella for patients presenting to the hospital and through CarePlus patients are separated using the CarePlus eligibility scale. If the patient qualifies for any other state or federal program, or has third party insurance, then they are either enrolled into the respective health assistance program they are qualified for, or their third party insurance company is billed for services rendered.

According to Juanita Sanders, Community Health System has been very effective in qualifying individuals for Medicaid and as a result, Community has received increased disproportionate share dollars, which are designed to offset the cost of treating

Medicaid and indigent patients.

POLITICAL FACTORS

Politically speaking, Hospital Districts have more funding leverage than Hospital Authorities, or other public hospitals, because they are authorized by law to levy property taxes to fund the care of the indigent population within their taxing region. However, the County Judge must approve any tax increase. As with Savelife Memorial Hospital, Community Health System must cope with competing interests for the tax dollars appropriated. In times of prosperity it is usually easier to convince the County to approve a tax increase, but during economic hardship tax increases are difficult, if not impossible, to obtain.

There is a growing concern in South Texas that county tax revenue is being spent for non-residents of the county. Understandably, residents do not want to fund out of county resident's health care with their tax dollars, and in the past few years they have voiced their displeasure to the County Judge; an elected official.

The Balanced Budget Act of 1997 has decreased Medicare reimbursements and has threatened the Medicaid and Medicare disproportionate share dollars appropriated to Texas from the federal government. These cutbacks have been particularly harsh on Hospital Districts, Public Hospitals, and Rural Hospitals. Grass-root's advocacy has persuaded congress to reduce the cuts of 1997, resulting in funding to hospitals in the amount of \$17

billion dollars in 1999-2000 (AHA News Now, 2000). The relief does not dismiss the need for Community Health System to be acutely aware of the policy changes that are taking place in Washington, D.C.

UNINSURED

The uninsured population for Community Health System's service area is estimated at 24 percent, with a total of over 327,421 people uninsured and 100,926 of those are under the age of 19 years (Texas Hospital Association, 2000).

The Children's Health Insurance Program (CHIP) is expected to cover many of the 100,926 uninsured children within the county. However, outreach programs are slow in getting started, and there is no available data at this time to suggest that any of these children are covered for health care. CarePlus has been able to provide coverage as a payer, but administration at Community Health System is quick to state that CarePlus is not an insurance policy.

Mrs. Sanders of Community Health System stated that when CarePlus was started in 1997 many uninsured people chose to visit other hospital emergency rooms, rather than visit Community's emergency room and undergo an interview for CarePlus eligibility. However, through CarePlus many of the emergency room "frequent visitors" were identified and assigned primary care physicians, thus resulting in a reduction in emergency room visits for the past three years (Archer & Townsend, 2000).

Community Health System has been extremely proactive in

developing operations that improve the health of their patrons, as well as improving reimbursement to the Health System. CarePlus is recognized as a benchmark for administering health care for the indigent and uninsured.

I have recommended to Community Health System that they produce data demonstrating the dollars that CarePlus has generated through reimbursement and costly treatment reductions.

FINANCIAL IMPACT

In 1999, Community Health System had 73,536 emergency room visits (the highest uncompensated service in the hospital) at an average cost of \$225 a visit. The same visit at a primary care clinic would have cost Community an average of \$46 a visit. Also of note is the \$6,533,891 that Community documented as uncompensated care for non-trauma care in the emergency room for 1999 (M. Cotton, personal communication, March 13, 2000).

As with Savelife Memorial Hospital, Community Health System has been severely impacted by the large amount of uncompensated care in the emergency room. As with Savelife, if half of the emergency room patients that were treated in 1999 were treated in a primary care clinic, Community Health System would have saved approximately \$9,848,418. This amount would be enough money to construct two 40,000 square foot primary care clinics and add almost 15 primary care physicians to staff the new clinics (M. Cotton, personal communication, March 13, 2000).

CONCLUSION

Throughout this paper I have discussed the many different components of a health care safety net that Texas has developed to care for the many indigent persons throughout Southwest Texas. Unfortunately, for myriad reasons many indigent persons are not enrolled in state or county sponsored programs. However, there are two reasons that emerged at every interview and relevant meeting that I attended during my research for this paper. First, the enrollment process for the Medicaid program, which is the first line of defense for treating the indigent, is extremely difficult and time consuming. For this reason many of the 600,000 Texans not enrolled in Medicaid fail to pursue enrollment. I've heard many Texan politicians publicly express concern that there are such a large number of Medicaid eligibles not enrolled. But, behind the scene it is no secret that if all 600,000 eligible persons were to sign up for Medicaid tomorrow, that Texas would not be able to fund the program. So, do Texas' elected officials really want to ensure enrollment of all Medicaid eligible persons? If they do, then why haven't they been more proactive in funding statewide outreach programs to capture this large number of indigent persons? Second, there is an extremely large population of undocumented immigrants in Southwest Texas. Many of these individuals would be eligible for Medicaid if they only applied. Unfortunately, they fear that by coming in contact with United States government agencies they will be deported back to Mexico. For additional information on Medicaid eligibility refer to appendix J.

The lack of full medical coverage for the indigent population in Texas is only one reason for increasing uncompensated care. Another related component to the cause of uncompensated care is the rising number of uninsured. I don't believe that insurance, in and of itself, will necessarily improve their health. However, covered individuals are more likely to seek care when they initially become ill, rather than waiting until treatment is emergent. By seeking care early, the patient enters the health care continuum at the least expensive phase, thus reducing the overall operating cost of the treatment facility. If uninsured, a patient's treatment cost often becomes uncompensated, because uninsured persons often can't afford the out-of-pocket expense of entering the health care continuum when they are most ill.

Interestingly, employer-based health insurance trails the national average in Texas. Only 56.5 percent of Texas workers receive employer-based health insurance coverage, compared to a national average of 61.1 percent. Almost 70 percent of the state's uninsured adults have jobs, but many work in personal services or agriculture, which typically do not provide health insurance, or work for small employers (Texas Hospital Association, 2000).

I analyzed how an urban and rural facility provides care for the indigent populations they are responsible for. Expecting negative margins, I found that each facility was very efficient in their spending patterns and in their ability to gain capital to maintain a positive margin. However, I am concerned that

both health treatment organizations rely heavily on disproportionate share compensation from the government. These funds, designed to assist health care facilities that treat a disproportionate share of indigent and Medicaid persons, are at great risk of being discontinued as Congress continues to cut government spending for health care. Government is the largest payer for a majority of Texas hospitals, and for Savelife Memorial Hospital and Community Health System, it is the largest payer. Medicare reimbursement reductions (Balance Budget Act 1997) and impending cuts in disproportionate share dollars are sure to have devastating results on both hospitals.

In 1997 Community Health System developed CarePlus, a managed care model to care for the indigent population of their service area. This program has received national attention for its ability to involve all patients in paying for their health care treatment, no matter how little money they have to do so, thus increasing reimbursements over 300 percent since its inception (J. Sanders, personal communication, February 18, 2000). CarePlus has also reduced the amount of non-emergent visits to the emergency room by assigning each patient enrolled in CarePlus a primary care physician, who is an employee of Community Health System. Community has recently begun to expand their CarePlus operations to use physician group practices and pay them for patients using the Medicare payment scale.

Savelife Memorial Hospital is hampered by its location in a rural setting. Its ability to maintain a positive margin is directly related to the half-cent sales tax that Savelife

receives to pay for indigent health care. The half-cent sales tax is not popular among the tax paying voters in the area. They believe that the money is being spent on undocumented immigrants that are not making an effort to pay for their care and are not contributing to the community through taxation. True or not, this public perception is drawing attention from the County Judge (the elected official that approved the half-cent tax), and political pressure could cause the half-cent tax to be discontinued. Of note is the County Judge's responsibility to expend eight percent of the general revenue levy on indigent health care for the county. Last year, the county only expended \$21,789.20, just .08 percent of the general revenue levy (Texas Hospital Association, 2000).

Uncompensated care has a cancer-like affect on hospitals. It slowly eats away at profits and those profits soon become deficits. Deficits lead to reductions in services, which later lead to limited access to quality care. This leads to overuse of the emergency room by both insured and uninsured populations, due to a lack of an alternative. Emergency room services are the most expensive in a hospital, and when you combine increased emergency room visits with little or no reimbursement, the results are a negative margin and eventual closure. In 1997 the GSAHC membership lost over \$503 million in uncompensated care (Archer & Townsend, 2000). There are many reasons for uncompensated care; poor collecting procedures, uninsured patients, underinsured patients, charity care for indigents, Medicaid eligible persons not enrolled in the program, and low

Medicare and Medicaid reimbursement rates for procedures.

In the next few years, uncompensated care may be the demise of many rural and small urban hospitals. However, it is important to note that uncompensated care is the effect of many root causes. In order for health care organizations to reduce their uncompensated care they must address the causes individually, and addressing the uninsured is where I would start.

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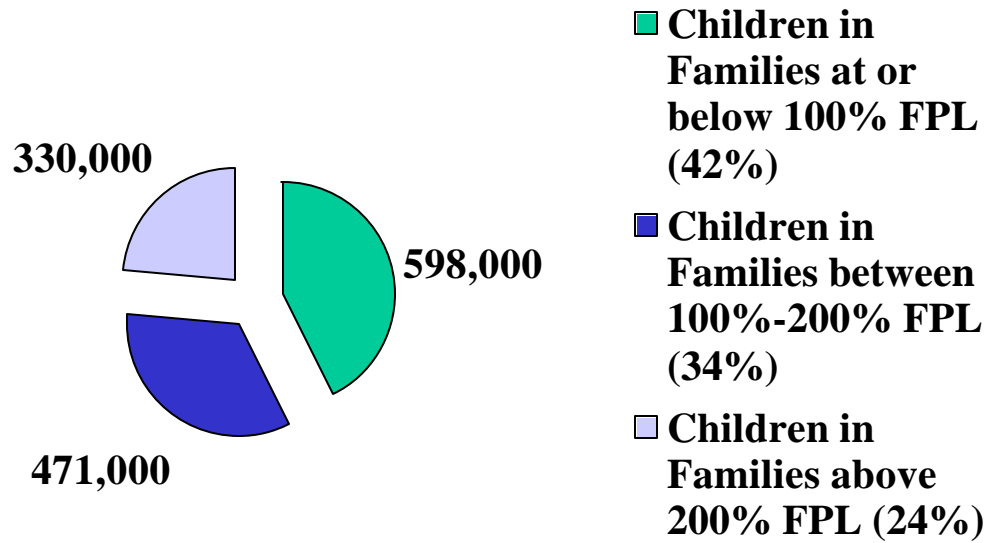
Appendix A

Income Cap for CHIP: 200 percent of federal poverty level (1999)		
Family Size	Annual	Monthly
1	\$16,480	\$1,373
2	\$22,120	\$1,843
3	\$27,760	\$2,313
4	\$33,400	\$2,783

(Center for Public Policy Priorities, 1999)

Appendix B

Texas' Uninsured Children, 2001



(Center for Public Policy Priorities, 1999)

Appendix C

Appendix D

Appendix E

Appendix F

Appendix G

DEFINITIONS

AFDC - Aid to Families with Dependent Children. This program's name was recently changed to **TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)**. Children who qualify for AFDC assistance also receive Medicaid benefits.

AGED - People 65 and older.

BAD DEBT - payment for health care services a provider anticipated, but did not receive or uncollectable inpatient and outpatient charges that result from the extension of credit.

BALANCED BUDGET ACT (BBA) (Public Law 105-33) - A federal law passed in 1997 designed to achieve substantial reductions in spending to balance the federal budget by the year 2002. The law made several changes to Medicaid, Medicare and expanded funding for child health. Changes are projected to attain federal savings of \$130 billion between 1998 and 2002.

CHARITY-CARE - the unreimbursed cost to a hospital of providing funding, or otherwise financially supporting health care services on an inpatient or outpatient basis to a person classified by the hospital as financially or medically indigent or providing, funding, or otherwise financially supported health care services provided to financially indigent patients through other nonprofit or public outpatient clinics, hospitals, or health care organizations.

CHILDREN'S HEALTH INSURANCE PLAN (CHIP) - The Balanced Budget Act of 1997 (BBA), enacted on August 5, 1997, established a new state children's health insurance program by adding Title XXI to

the Social Security Act and amending the Medicaid statute. The purpose of this new program is to provide funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children.

DISPROPORTIONATE SHARE (DISPRO OR DSH) - A program which provides additional reimbursement to hospitals which serve a disproportionate share of low income patients to compensate for revenues lost by serving needy Texans.

DSH HOSPITAL - A hospital which serves a higher than average number of Medicaid and medically indigent patients.

FEDERAL POVERTY LEVELS (FPL) - income guidelines established annually by the federal government. Public assistance programs usually define income limits in relation to FPL.

FINANCIALLY INDIGENT - an uninsured or underinsured person who is accepted for care with no obligation or a discounted obligation to pay for the services rendered based on the hospital's eligibility system.

HEALTH CARE FINANCING ADMINISTRATION (HCFA) - The federal agency responsible for administering Medicare and overseeing state administration of Medicaid.

HOSPITAL AUTHORITY - A public hospital responsible for treating the indigent population within a given area of responsibility. Hospital Authorities are not authorized to levy taxes for the purpose of funding indigent health care.

HOSPITAL DISTRICT - A public hospital responsible for treating the indigent population within the county it serves. Unlike Hospital Authorities, Hospital Districts are authorized to levy

property taxes to fund indigent health care for indigents living in their taxing areas. This may be an entire county, part of a county or in some cases, all or part of several counties.

COUNTIES - County government is responsible for all areas not served by hospital districts or public hospitals. This may be all or part of a county. Presently, 136 Texas counties have responsibility under the CHICP.

COUNTY INDIGENT HEALTH CARE PROGRAM (CIHCP)- A program mandated by state legislation in 1985 to capture indigent persons that do not qualify for Medicaid or any other state program. CIHCP is the payer of last resort and because of its stringent qualification criteria (17 percent of the FPL or lower), CIHCP treats only a small portion of the indigent population in Texas.

MEDICAID - A joint federal-state entitlement program that pays for medical care on behalf of certain groups of low-income persons. The program was enacted in 1965 under Title XIX of the Social Security Act.

MEDICAID ENROLLMENT BROKER - Part of the Texas Medicaid Administrative System (TMAS). Assists Medicaid clients enrolling in Medicaid managed care and in selecting managed care options.

MEDICAID ENROLLEE - An individual eligible for services from a health plan either as a subscriber or as a dependent.

MEDICARE - the nation's largest health insurance program financed by the federal government, which covers approximately 37 million Americans. Medicare provides insurance to:

1) people who are 65 years old;

- 2) people who are disabled; and
- 3) people with permanent kidney failure.

PART A - Medicare hospital insurance that helps pay for medically necessary inpatient hospital care, and, after a hospital stay, for inpatient care in a skilled nursing facility, for home care by a home health agency or hospice care by a licensed and certified hospice agency.

PART B - Medicare medical insurance that helps pay for medically necessary physician services, outpatient hospital services, outpatient physical therapy and speech pathology services, and a number of other medical services and supplies that are not covered by the hospital insurance. Part B will pay for certain inpatient services if the beneficiary does not have Part A.

MEDICALLY INDIGENT - a person whose medical or hospital bills after payment by third-party payers exceed a specified percentage of the patient's annual gross income, determined in accordance with the hospital's eligibility system, and the person is financially unable to pay the remaining bill.

PAYER OF LAST RESORT - a third party payer, such as CIHCP, that assumes financial responsibility for treating patients that do not qualify for any other state or federal health care assistance program.

PREVENTIVE CARE - comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examination, immunization and well person care.

PRIMARY CARE PHYSICIAN (PCP) - a physician or provider who has agreed to provide a medical home to Medicaid recipients and who is responsible for providing initial and primary care to patients, maintaining the continuity of patient care and initiating referral for care.

PUBLIC HOSPITALS - All public hospitals are responsible for their legally defined service area. This includes county hospitals, city hospitals and various hospital authorities.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) - Formerly Aid to Families with Dependent Children (AFDC), TANF is a product of recent Congressional welfare reform.

TITLES OF THE 1965 SOCIAL SECURITY ACT -

II - Old Age, Survivors and Disability Insurance Benefits
(Social Security or OASDI)

IV-A - TANAF; WIN Social Services

IV-B - Child Welfare

IV-D - Child Support

IV-E - Foster Care and Adoption

IV-F - Job Opportunities and Basic Skills Training

V - Maternal and Child Health Services

XV - SSI

XVIII - Medicare

XIX - Medicaid

XX - Social Services

XXI - CHIP - Added by BBA of 1997

TEXAS DEPARTMENT OF HEALTH (TDH) - Medicaid operating agency responsible for Purchased Health Services, the Vendor Drug

program, Medical Transportation, THSteps, and family planning. TDH also provides assistance with claims processing to certain other operating agencies through a contract with NHIC, and establishes some rules related to Medicaid managed care.

TEXAS DEPARTMENT OF HUMAN SERVICES (TDHS) - Medicaid operating agency responsible for a number of services and programs including Personal Care, DAHS, Nursing Facilities, Swing Bed, Emergency Dental, PASARR, Hospice, Goal-Directed Therapy, Long Term Care Licensing, Survey and Certification, Nurse Aide Training, and Waivers (CLASS, MDCP, PACE, NF). TDHS also provides assistance to other Medicaid operating agencies in the areas such as automated systems, Medicaid eligibility determination, rate setting, federal funds analysis and appeals.

UNCOMPENSATED CARE - health care services for which the patient and/or the payer either was not billed or failed to pay.

Uncompensated care includes both charity care and bad debt.

Appendix H

Appendix I

Appendix J

TEXAS LINKS

Center for Public Policy Priorities

<http://www.cppp.org>

Greater San Antonio Hospital Council

<http://www.gsahc.org>

Kaiser Family Foundation Texas Health Facts

<http://www2.kff.org/docs/state/states/tx.html>

State of Texas Government Information

<http://www.texas.gov>

Texas Department of Health

<http://www.tdh.texas.gov/>

Texas Hospital Association

<http://www.thaonline.com>

Texas Medicaid

<http://www.hhsc.state.tx.us/med/med.htm>

Texas Health & Human Services Commission

<http://www.hhsc.state.tx.us>

Texas Healthcare Information Council

<http://www.thcic.state.tx.us>

Texas Department of Insurance

<http://www.tdi.state.tx.us>

Texas Hospitals on the Web

<http://www.thaonline.com/hospweb.html>

University Health System

<http://www.universityhealthsystem.com>

NATIONAL LINKS

Agency for Health Care Policy & Research

<http://www.ahcpr.gov>

American College of Healthcare Executives

<http://www.ache.org>

American Hospital Association

<http://www.aha.org>

American Medical Association

<http://www.ama-assn.org>

American Public Health Association

<http://www.apha.org>

Arthur Anderson Knowledge Space

<http://www.knowledgespace.com>

Center for Health Strategies

<http://www.chcs.org>

Children's Health Insurance Program

<http://www.hcfa.gov/init/children.htm>

Department of Health and Human Services

<http://www.dhhs.gov>

Federal Web Locator

<http://www.law.vill.edu/fed-agency>

Health Care Finance Administration

<http://www.hcfa.gov>

Health Insurance Association of America

<http://www.hiaa.org>

Health Hippo(policy and reg for healthcare)

<http://hippo.findlaw.com>

Health Resources and Services Administration

<http://www.hrsa.dhhs.gov>

Healthfinder

<http://www.healthfinder.gov>

Medicaid

<http://www.hcfa.gov/medicaid/medicaid.htm>

Medicare

<http://www.hcfa.gov/medicare/medicare.htm>

Modern Healthcare Magazine

<http://www.modernhealthcare.com>

National Center for Health Statistics
<http://www.cdc.gov/nchs>

National Center for Policy Analysis
<http://www.ncpa.org>

National Institute of Health
<http://www.nih.gov>

National Library of Medicine
<http://www.nlm.nih.gov>

National Rural Health Association
<http://www.nrharural.org>

Public Health Service
<http://phs.os.dhhs.gov/phs>

United States Census Bureau
<http://www.census.gov>

Type of Facility or Program Providing Health Care
by County
GSAHC Membership

COUNTY	Population estimate 1998	Est Uninsured age 0-18 1998	Est Uninsured total 1998	Est Percent Uninsured 1998
Atascosa	36,181	2,916	8,923	25%
Bandera	13,542	697	2,806	21%
Bexar	1,342,480	100,926	327,421	24%
Caldwell	31,480	2,245	7,581	24%
Comal	71,060	4,002	14,996	21%
De Witt	20,298	1,251	4,457	22%
Dimmit	11,163	1,011	3,035	27%
Edwards	2,476	192	600	24%
Frio	16,272	1,328	4,291	26%
Gillespie	19,514	963	3,622	19%
Gonzales	18,101	1,350	4,197	23%
Guadalupe	81,951	5,649	18,754	23%
Hays	83,924	5,279	20,526	24%
Karnes	15,692	1,035	3,679	23%
Kendall	18,445	1,098	3,869	21%
Kerr	41,390	2,400	8,033	19%
Kinney	3,329	205	693	21%
LaSalle	6,346	503	1,695	27%
Maverick	43,366	4,465	12,461	29%
Medina	33,624	2,294	7,795	23%
Real	2,525	157	561	22%
Travis	640,223	42,493	150,866	24%
Uvalde	25,752	2,152	6,535	25%
Val Verde	43,626	3,895	11,425	26%
Victoria	80,074	5,616	18,529	23%
Wilson	28,909	2,085	6,670	23%
Zavala	13,569	1,260	3,862	28%
Total	2,745,312	197,467	657,882	24%
US Census Bureau				
Texas Hospital Association				
American Hospital Association				

Type of Facility or Program Providing Health Care
by County
GSAHC Membership

Est Per Capita Median Income 1995	Est Poverty Population 1995	Est Percent in Poverty 1995	Uninsured below Poverty 1998
\$ 25,420	8,747	25.2%	3,535
\$ 31,921	1,743	12.2%	622
\$ 29,815	254,595	19.4%	119,196
\$ 26,604	6,497	21.6%	2,767
\$ 37,595	7,183	10.5%	3,274
\$ 24,468	4,334	23.8%	1,695
\$ 16,779	4,564	43.4%	1,724
\$ 18,890	1,090	30.8%	266
\$ 18,949	5,504	38.0%	2,203
\$ 29,494	2,230	11.6%	832
\$ 21,879	4,723	27.0%	1,767
\$ 32,574	11,928	15.9%	5,293
\$ 35,119	10,728	14.1%	5,702
\$ 21,225	3,641	29.2%	1,619
\$ 38,991	2,056	10.4%	698
\$ 28,644	6,132	15.0%	2,287
\$ 19,768	892	25.6%	293
\$ 19,133	2,056	37.5%	880
\$ 17,150	21,837	46.4%	7,633
\$ 29,125	6,849	20.7%	2,648
\$ 21,866	771	28.7%	245
\$ 38,368	87,177	12.9%	39,058
\$ 21,598	7,964	31.5%	3,195
\$ 22,133	13,932	32.5%	5,630
\$ 34,464	14,108	17.4%	5,586
\$ 31,383	4,638	16.0%	1,925
\$ 15,162	5,859	48.3%	2,357
\$ 26,241	501,778	25%	222,930

GSAHC Membership

[illegible]

Sevice	Bad Debt	Charity Care	Uncompensated Care	Outstanding Projects	Layoffs	Cancelled Medicaid Programs
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Uvalde County	Medicaid Recipiants	Medicaid Expenditures	Uninsured Population
	6,780	\$18,221,348	

Medicare	CHIP	Profit Margin	Percent of net patient revenue (Uncomp Care)
		3%	5%